

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3311	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 01/27/2014
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

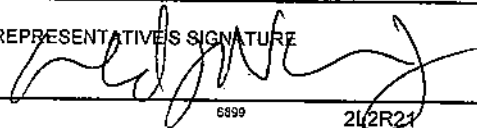
NHC HEALTHCARE, CHATTANOOGA

**2700 PARKWOOD AVE
CHATTANOOGA, TN 37404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>Based on observations, testing, and records review on 1/27/14, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing Homes and its referenced publications.</p>	N 002	(Page Intentionally Blank)	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

ADM

(X8) DATE

2/12/14

STATE FORM

6899

212R21

If continuation sheet 1 of 1